# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
## CERTIFICATE OF DEATH

06130 — 06186

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: WORCESTER — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN RURAL
c. LENGTH OF STAY IN 1b: typo.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN R7D 2 — 23-1
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: WILLIAM — Middle: B. — Last: DAVIES

4. DATE OF DEATH: Month: APRIL — Day: 17 — Year: 1966

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: SEPT. 24, 1881

9. AGE (In years last birthday): 84 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MASTER MECHANIC

10b. KIND OF BUSINESS OR INDUSTRY: MASTER MECHANIC

11. BIRTHPLACE (County & State, or foreign country): FAIRFIELD, CONN.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: DAVID B. DAVIES

14. MOTHER'S MAIDEN NAME: ADDIE CONABLE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO — (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: 047-07-252

17. INFORMANT: WILLIAM T. DAVIES — Address: BERLIN, Md. RFD 2

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Myocarditis — INTERVAL BETWEEN ONSET AND DEATH

4222

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Chronic Myocarditis

DUE TO (c): Senility

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Mar., 1965, to Apr. 17, 1966, that (I) (we) last saw the deceased alive on Apr. 6, 1966, and that death occurred at 8 A M, from the causes and on the date stated above.

22a. SIGNATURE: Clifford E. Schott M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Apr. 19, 1966

22c. PHYSICIAN'S NAME (Type): Clifford E. Schott, M.D.

22d. ADDRESS: Berlin, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: APRIL 21, 1966

23c. NAME OF CEMETERY OR CREMATORY: LAKEVIEW CEM.

23d. LOCATION (City, town or county) (State): BRIDGEPORT CONN.

24. FUNERAL DIRECTOR: Anna A. Burbage — ADDRESS: Berlin Md

25a. RECD BY REGISTRAR DATE: APR 22 1966

25b. REGISTRAR'S SIGNATURE:

VR A15 (4)
15M 4-64

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FOR STATE HEALTH DEPT.

(M)

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06191

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06187

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give (Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
3500 4-64

BP

1. PLACE OF DEATH
   a. COUNTY: Worcester — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke City
   c. LENGTH OF STAY IN 1b: Life
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 407 Market Street

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Worcester
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke City
   d. STREET ADDRESS: 407 Market Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

23-1

3. NAME OF DECEASED (Type or print): First CLAYTON Middle THOMAS Last DAVIS

4. DATE OF DEATH: Month April Day 26 Year 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 23, 1891

9. AGE (In years last birthday): 74 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retail Merchant

10b. KIND OF BUSINESS OR INDUSTRY: Hardware Store

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward Samuel Davis

14. MOTHER'S MAIDEN NAME: Ella Boston

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No

(If yes give war or dates of service): ---

16. SOCIAL SECURITY NO.: 215-16-3495

17. INFORMANT Address: Mrs Naomi S. Davis, Pocomoke City, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 14 minutes

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerotic Heart Disease — years

DUE TO (c):

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, ferm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: David Rafat M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): DAVID RAFAT

Address (Street, city, town, or county)

22. DATE SIGNED: 4-26-66

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4-28-1966

23c. NAME OF CEMETERY OR CREMATORY: Presbyterian

23d. LOCATION (City, town or county) (State): Pocomoke City, Maryland

24. FUNERAL DIRECTOR: Robert H. Watson — ADDRESS: Pocomoke City, Md.

25e. REC'D BY REGISTRAR DATE: MAY 2 1966

25b. REGISTRAR'S SIGNATURE: J Charles Judge

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06192

## CERTIFICATE OF DEATH

06188

1. **PLACE OF DEATH**
   a. COUNTY: WORCESTER — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress):

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: MARYLAND — b. COUNTY: WORCESTER
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ST. MARTINS, BERLIN 23-1
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: ARALANTA — Middle: S. — Last: DENNIS

4. **DATE OF DEATH**: Month: APRIL — Day: 11 — Year: 1966

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: MAY 1, 1874

9. AGE (In years last birthday): 91 yrs.
   IF UNDER 1 YEAR: Months: — Days: —
   IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (County & State, or foreign country): BERLIN, MD

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: THOMAS BIRCH

14. MOTHER'S MAIDEN NAME: MARTHA BOWEN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, of unknown): NO — (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: NO

17. **INFORMANT** Address: MR. ZADOK SMACK, BERLIN MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Acute Myocarditis
   DUE TO (b): Chronic Myocarditis
   DUE TO (c): Senility
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4222
   INTERVAL BETWEEN ONSET AND DEATH:
   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1-1-, 1965 to 4-11-, 1966, that (I) (we) last saw the deceased alive on 4-10-66, and that death occurred at 10:4 M, from causes and on the date stated above.

22a. SIGNATURE: Clifford E. Schott M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): Clifford E. Schott M.D.

22d. ADDRESS: BERLIN MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 4/13/66

23c. NAME OF CEMETERY OR CREMATORY: EVERGREEN

23d. LOCATION (City or Town) (County) (State): BERLIN Wor. MD

24. FUNERAL DIRECTOR: Anna A. Burbage — ADDRESS: Berlin Md.

25a. REC'D BY REGISTRAR DATE: APR 14 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

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# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

06193 06189

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. CDUNTY: Worcester
MARYLAND
b. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke City
c. LENGTH OF STAY IN 1b: 25 years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 302 15th Street

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. CDUNTY: Worcester
c. CITY DR TDWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke City
d. STREET AODRESS: 302 15th Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF OECEASED (Type or print): First THOMAS Middle HYMAN Last HURLEY
4. DATE OF DEATH: Month April Day 24 Year 1966
5. SEX: Male
6. CDLDR DR RACE: White
7. MARRIEO ☒ NEVER MARRIEO ☐ WIDDWED ☐ DIVORCED ☐
8. DATE DF BIRTH: Sept. 9, 1913
9. AGE (In years last birthday): 52 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATIDN (Give kind of work done during most of working life, even if retired): Salesman
10b. KIND OF BUSINESS OR INDUSTRY: Automotive
11. BIRTHPLACE (County & State, or foreign country): Accomack County, Virginia
12. CITIZEN OF WHAT CDUNTRY? U.S.A.

13. FATHER'S NAME: William A. Hurley
14. MDTHER'S MAIDEN NAME: Lula M. Watson

15. WAS OECEASED EVER IN U.S. ARMEO FDRCES? (Yes, no, or unkown): No
(If yes give war or dates of service): --
16. SDCIAL SECURITY ND.: 161-05-6455
17. INFDRMANT: Mrs Estelle Hurley, Address: Pocomoke City, Md.

MEDICAL CERTIFICATION

18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Minutes
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arterio-Sclerotic Heart Disease — years
DUE TO (c):

PART II. OTHER SIGNIFICANT CONOITIONS CONTRIBUTING TO OEATH BUT NOT RELATEO TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIOENT WAS UNOERLYING ☐ OR CONTRIBUTING ☐ CAUSE DF OEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. OESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Oay, Year Hour a.m. p.m. 19
20d. INJURY DCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan 30, 1966, to April 24, 1966, that (I) (we) last saw the deceased alive on Apr. 24, 1966, and that death occurred at 1:45 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Charles W Trader M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4-25-66
22c. PHYSICIAN'S NAME (Type): Charles W. Trader, M.D.
22d. ADDRESS: Pocomoke City, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. OATE THEREOF: 4-26-1966
23c. NAME DF CEMETERY: Nelson Cemetery
23d. LOCATION (City, town or county) (State): Accomack County, Virginia

24. FUNERAL DIRECTDR: Robert H. Watson
ADDRESS: Pocomoke City, Md.
25a. REC'D BY REGISTRAR DATE: APR 29 1966
25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4)
15M 4-64

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FOR STATE HEALTH DEPT.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06194

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06190

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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|---|---|
| 1. PLACE OF DEATH a. COUNTY: Worcester | 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE: Maryland b. COUNTY: Worcester |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke City | c. LENGTH OF STAY IN 1b: 32 years |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke City | 23.1 |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 6 Bridge Street | d. STREET ADDRESS: 6 Bridge Street |
| e. IS RESIDENCE ON A FARM? YES ☐ NO ☒ | |

| 3. NAME OF DECEASED (Type or print) First | Middle | Last | 4. DATE OF DEATH Month | Day | Year |
|---|---|---|---|---|---|
| MARION | CANDACE | LONG | April | 1 | 1966 |

| 5. SEX | 6. COLOR OR RACE | 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | | Oct. 11, 1879 | 86 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | -- | Maryland | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Edward Tull | Susan Payne |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) | (If yes give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|---|
| No | -- | None | Mrs Verlie Bromley, Princess Anne, Md. |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Failure — INTERVAL BETWEEN ONSET AND DEATH: 3-4 days

4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Arteriosclerotic Heart — 4 years.

DUE TO (c) Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

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| 20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
|---|---|

| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
|---|---|---|---|
| | | | |

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: David Rafat M.D.

EXAMINER'S NAME (Type): DAVID RAFAT

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

22. DATE SIGNED: 4-1-66.

2

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City, town or county) (State) |
|---|---|---|---|
| Burial | 4-3-1966 | Olivet Cemetery | Worcester County, Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Robert H. Watson Pocomoke City, Md. | APR 5 1966 | J. Charles Judge |

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1 (M)

FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06195

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06191

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Stockton
c. LENGTH OF STAY IN 1b: 58 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): --

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Stockton
d. STREET ADDRESS: --
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

23-1

3. NAME OF DECEASED (Type or print): First HOMER — Middle LEE — Last MASON — JR.

4. DATE OF DEATH: Month April — Day 29 — Year 19 66

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 20, 1908

9. AGE (In years last birthday): 58 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman

10b. KIND OF BUSINESS OR INDUSTRY: Hardware

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Homer Lee Mason

14. MOTHER'S MAIDEN NAME: Sefronia Pollitt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): --

16. SOCIAL SECURITY NO.: 063-22-3316

17. INFORMANT Address: Mrs Margie Mason, Stockton, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Few Minutes
DUE TO (b): Hypertensive & Arteriosclerotic Heart Disease — Years
DUE TO (c):

4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: David Rafat M.D.

EXAMINER'S NAME (Type): DAVID RAFAT

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

22. DATE SIGNED: 5-2-66

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5-1-1966

23c. NAME OF CEMETERY: Gunby Presbyterian

23d. LOCATION (City, town or county) (State): Stockton, Maryland

24. FUNERAL DIRECTOR: Robert H. Watson — ADDRESS: Pocomoke City, Md.

25a. REC'D BY REGISTRAR DATE: MAY 3 1966

25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
3500 4-64

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06196

## CERTIFICATE OF DEATH

06192

1

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

| | |
|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY: WORCESTER — MARYLAND<br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN<br>c. LENGTH OF STAY IN 1b:<br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): BERLIN NURSING HOME | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE: Maryland — b. COUNTY: WORCESTER<br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OCEAN CITY 23.1<br>d. STREET ADDRESS: 60TH STREET<br>e. IS RESIDENCE ON A FARM? YES ☐ NO ☒ |

| 3. NAME OF DECEASED (Type or print) First | Middle | Last | 4. DATE OF DEATH Month | Day | Year |
|---|---|---|---|---|---|
| MARIE | A | MORRIS | APRIL | 18 | 1966 |

| 5. SEX | 6. COLOR OR RACE | 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | | JUNE 18, 1893 | 72 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| MOTEL OWNER | | WAVERLY, NEW JERSEY | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| WALTER A. ALBEY | LOTTIE B. WOODRUFF |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|
| No | 217-52-7701 | JAMES S. MORRIS | OCEAN CITY, MD. |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARCINOMA, COLON. — INTERVAL BETWEEN ONSET AND DEATH: 2 years
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):
1538

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

| 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
|---|---|---|---|---|---|
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |

21. **I certify** that (I) (~~this hospital~~) attended the deceased from FEB 22, 1966, to APRIL 18, 1966, that (I) (~~we~~) last saw the deceased alive on APRIL 13 1966, and that death occurred at 1035 A.M. from causes and on the date stated above.

| 22a. SIGNATURE | M.D. | ATTENDING PHYS. ☒ | MED. DIRECTOR ☐ | STAFF PHYS. ☐ | 22b. DATE SIGNED |
|---|---|---|---|---|---|
| F J Townsend Jr | | | | | APR 19, 1966 |

| 22c. PHYSICIAN'S NAME (Type) | 22d. ADDRESS |
|---|---|
| F J TOWNSEND, JR | Ocean City, Md |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) | (County) | (State) |
|---|---|---|---|---|---|
| BURIAL | APRIL 21, 1966 | ARLINGTON NATIONAL CEM. | WASHINGTON | | D.C. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Anne A. Burbage | Berlin, Maryland | DATE APR 22 1966 | J Charles Judge |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06197

## CERTIFICATE OF DEATH

06193

1. **PLACE OF DEATH**
   a. COUNTY: WORCESTER — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN
   c. LENGTH OF STAY IN 1b: 40 YRS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address)

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: MARYLAND — b. COUNTY: WORCESTER
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN
   d. STREET ADDRESS: WEST ST
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. **NAME OF DECEASED** (Type or print): First GEORGE — Middle H. — Last PARSONS

4. **DATE OF DEATH**: Month APR. — Day 28 — Year 1966

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: AUG. 6, 1892

9. AGE (In years last birthday): 73 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10b. KIND OF BUSINESS OR INDUSTRY: FARMER

11. BIRTHPLACE (County & State, or foreign country): PITTSVILLE, MD

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WESLEY PARSONS

14. MOTHER'S MAIDEN NAME: SALLY PARSONS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO / NO

16. SOCIAL SECURITY NO.: 217-30-8664

17. INFORMANT — Address: MRS. GEO. H. PARSONS BERLIN MD

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Congestive Heart failure
   DUE TO
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   (b): Arteriosclerotic Heart disease 10 yrs.
   DUE TO
   (c):
   INTERVAL BETWEEN ONSET AND DEATH

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4/25, 1966, to 4/28, 1966, that (I) ~~(we)~~ last saw the deceased alive on 4/28 1966 and that death occurred at ____ M, from causes and on the date stated above.

22a. SIGNATURE: Frank E. Gantz M.D. — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Frank E. Gantz

22d. ADDRESS: 5 Bay St Berlin

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 4/28/66

23c. NAME OF CEMETERY OR CREMATORY: EVERGREEN

23d. LOCATION (City or Town) (County) (State): BERLIN WOR.

24. FUNERAL DIRECTOR: Amos A. Purnell — ADDRESS: Berlin Md.

25a. REC'D BY REGISTRAR — DATE: MAY 2 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
## CERTIFICATE OF DEATH

06198 — 06194

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Stockton
c. LENGTH OF STAY IN 1b: 4 months
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Holland Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Stockton 23-1
d. STREET ADDRESS: Line Road
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First ESTELLE — Middle ANNA — Last PETTIT

4. DATE OF DEATH: Month April — Day 16 — Year 19 66

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Nov. 26, 1883

9. AGE (In years last birthday): 82 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (County & State, or foreign country): Worcester County, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Major W. Pilchard

14. MOTHER'S MAIDEN NAME: Annie Collins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service): --

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: W. E. Pettit, Stockton, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO (b): Probable Malignancy — 12 mo.
DUE TO (c): ? Intra abdominal

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. 1992

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan, 19 65, to Apr, 19 66, that (I) (we) last saw the deceased alive on Apr. 14 19 66, and that death occurred at ____M, from the causes and on the date stated above.

22a. SIGNATURE: David Rafat — M.D. — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): DAVID RAFAT

22d. ADDRESS: Snow Hill Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4-19-1966

23c. NAME OF CEMETERY OR CREMATORY: Union Greenbackville

23d. LOCATION (City, town or county) (State): Worcester County, Md.

24. FUNERAL DIRECTOR: Robert H. Watson — ADDRESS: Pocomoke City, Md.

25a. REC'D BY REGISTRAR DATE: APR 25 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

1 B

FOR STATE HEALTH DEPT.

M

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06199

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06195

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 3 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1. **PLACE OF DEATH**
   a. COUNTY: Worcester — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Snow Hill
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address):

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Virginia
   b. COUNTY: Accomack
   c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Onancock
   d. STREET ADDRESS: RFD #2
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

52-3

3. **NAME OF DECEASED** (Type or print): First: Robert — Middle: J. — Last: Riley, Jr.

4. **DATE OF DEATH**: Month: April — Day: 25 — Year: 1966

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Mar 18, 1912

9. AGE (In years last birthday): 54 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Timber

11. BIRTHPLACE (State or foreign country): Onancock, Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert J. Riley Sr.

14. MOTHER'S MAIDEN NAME: Maggie Lewis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): WWII

16. SOCIAL SECURITY NO.: 225-18-3909

17. **INFORMANT**: Essie Savage — Address: Onancock, Va.

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Minutes

4201

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic Heart — years
DUE TO (c): Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

2

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy [X], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [X] Accident [ ] Suicide [ ] Homicide [ ] Undetermined manner [ ]

2

ACTUAL SIGNATURE: David Rafat M.D.

EXAMINER'S NAME (Type): DAVID RAFAT

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

Address (Street, city, town, or county):

DATE SIGNED: 4-25-66

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4-30-66

22c. NAME OF CEMETERY OR CREMATORY: Gunter Cemetery

22d. LOCATION (City, town, or county) (State): Onancock, Va.

23. FUNERAL DIRECTOR: C. A. Humbles — ADDRESS: Accomac, Va.

24a. REC'D BY REGISTRAR — DATE: APR 28 1966

24b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME
5M 1/63

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06200

# CERTIFICATE OF DEATH

06196

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke City
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Hartley Hall

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

23-1

3. NAME OF DECEASED (Type or print): First: Elma — Middle: B. — Last: Scarborough

4. DATE OF DEATH: Month: April — Day: 4 — Year: 19 66

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 12 1876

9. AGE (In years last birthday): 90 yrs.
IF UNDER 1 YEAR: Months: — Days:
IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Snow Hill, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George T. Bratten

14. MOTHER'S MAIDEN NAME: Agusta C. Richardson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): ------

16. SOCIAL SECURITY NO.: 140289237

17. INFORMANT: Address: Mrs. Willie A. Nock, Snow Hill, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 2-3 yrs.
443X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Myocarditis, chronic, severe — many yrs.
DUE TO
(c): Generalized Arteriosclerotic & Hypertensive C*V Disease, severe — many yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
(1) Obesity (2) Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept. 4, 1965, to April 4, 1966, that (I) (we) last saw the deceased alive on April 19 66 and that death occurred at 1:15 M, from causes and on the date stated above.

22a. SIGNATURE: N. E. Sartorius, Jr. M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☑

22b. DATE SIGNED: April 7, 1966

22c. PHYSICIAN'S NAME (Type): N.E.Sartorius, Jr., M.D.

22d. ADDRESS: 114 Market St., Pocomoke City, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/7/66

23c. NAME OF CEMETERY OR CREMATORY: Whatcoat Methodist

23d. LOCATION (City or Town) (County) (State): Snow Hill, Maryland

24. FUNERAL DIRECTOR: Truman G. Morris — ADDRESS: Snow Hill, Md.

25a. REC'D BY REGISTRAR DATE: APR 11 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M 06201

## CERTIFICATE OF DEATH

06197

**1. PLACE OF DEATH**
a. COUNTY: WORCESTER — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN
c. LENGTH OF STAY IN 1b: 87 YRS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): BERLIN NURSING HOME

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN
d. STREET ADDRESS: 23-1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

90

**3. NAME OF DECEASED** (Type or print): First MARY — Middle LEE — Last TAYLOR

**4. DATE OF DEATH**: Month APRIL — Day 2 — Year 1966

**5. SEX**: F

**6. COLOR OR RACE**: W

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

**8. DATE OF BIRTH**: APRIL 25, 1878

**9. AGE** (In years last birthday): 87 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): HOUSEWIFE

**10b. KIND OF BUSINESS OR INDUSTRY**: RET.

**11. BIRTHPLACE** (County & State, or foreign country): BERLIN MD

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: THOMAS F. JARVIS

**14. MOTHER'S MAIDEN NAME**: SARAH MARIAH COFFIN

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): NO
(If yes give war or dates of service): No

**16. SOCIAL SECURITY NO.**: 219-44-7381

**17. INFORMANT** — Address: MR. THOMAS K. TAYLOR BERLIN MD

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive heart failure
DUE TO
(b): Arteriosclerotic heart disease
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4200

INTERVAL BETWEEN ONSET AND DEATH: 10 years.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Month, Day, Year, Hour a.m. p.m. 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

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**21. I certify** that (I) ~~(this hospital)~~ attended the deceased from Sept, 19 62 to 4/2, 19 66, that (I) ~~(we)~~ last saw the deceased alive on 4/2 19 66, and that death occurred at 4:30 A M, from causes and on the date stated above.

**22a. SIGNATURE**: Frank E. Gantz Sr.
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED**: 4/4/66

**22c. PHYSICIAN'S NAME** (Type): Frank E. Gantz Sr.

**22d. ADDRESS**: 5 Bay St. Berlin Md.

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**23a. BURIAL, CREMATION, REMOVAL** (Specify): BURIAL

**23b. DATE THEREOF**: 4/4/66

**23c. NAME OF CEMETERY ~~OR CREMATORY~~**: BUCKINGHAM

**23d. LOCATION** (City or Town) (County) (State): BERLIN WOR. MD

**24. FUNERAL DIRECTOR**: Anna A. Bunting — **ADDRESS**: Berlin Md

BP

**25a. REC'D BY REGISTRAR** DATE: APR 7 1966

**25b. REGISTRAR'S SIGNATURE**: J. Charles Judge

1

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06202

## CERTIFICATE OF DEATH

06198

**1. PLACE OF DEATH**
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Berlin
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Berlin Nurseing Home

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
d. STREET ADDRESS: 23-1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

| 3. NAME OF DECEASED (Type or print) | First | Middle | Last | 4. DATE OF DEATH | Month | Day | Year |
|---|---|---|---|---|---|---|---|
| | Sadie | M. | Townsend | | April | 26 | 19 66 |

| 5. SEX | 6. COLOR OR RACE | 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | | April 29, 1884 | 81 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housekeeper | Domestic | Girdletree, Maryland | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Jake Brittingham | Katherine Pruitt |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give wor or dotes of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| No | ---- | 219053866 | Royce K. Townsend | Snow Hill, Md. |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO (b): Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Hypertension

331X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)

| 20c. TIME OF INJURY Month, Day, Yeor Haur o.m. p.m. 19 | 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ | 20e. PLACE OF INJURY (Hame, form, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
|---|---|---|---|---|---|
| | | | | | |

21. **I certify** that (I) (this hospital) attended the deceased from 4-1-, 1966, to 4-26-, 1966, that (I) (we) last saw the deceased alive an 4-26- 1966, and that death occurred at 2:30 M, from causes and an the date stated abave.

| 22a. SIGNATURE | M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 22b. DATE SIGNED |
|---|---|---|
| Chas R Lane | | 4-28-66 |

| 22c. PHYSICIAN'S NAME (Type) | 22d. ADDRESS |
|---|---|
| | Berlin Md. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 4/28/66 | Parsons Cemetery | Salisbury, Maryland |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Thomas F. Glenn | Snow Hill, Maryland | DATE MAY 2 1966 | J. Charles Judge |

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
## CERTIFICATE OF DEATH

06203 — 06199

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Whaleyville
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): xx

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Whaleyville
d. STREET ADDRESS: RFD
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Edward — Middle: Henry — Last: Vickers

4. DATE OF DEATH: Month, Day, Year: April 10, 1966 19

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Sept. 14, 1887

9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Own Farm

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Vickers

14. MOTHER'S MAIDEN NAME: Annie Mary Quillen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): xx
(If yes give war or dates of service): xx

16. SOCIAL SECURITY NO.: 214-36-5299

17. INFORMANT: Address: Annie M. Vickers Whaleyville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Apoplexy.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b): Diabetes
DUE TO (c): Hy Retension
260 X
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-1-50, 19 64 to 4-10-66, 19 , that (I) (we) last saw the deceased alive on 4-9-66 19 , and that death occurred at 7:20 M, from the causes and on the date stated above.

22a. SIGNATURE: Clifford E. Schott M.D. — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): CLIFFORD E SCHOTT M.D

22d. ADDRESS: BERLIN, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/13/66

23c. NAME OF CEMETERY OR CREMATORY: Dale

23d. LOCATION (City, town or county) (State): Whaleyville

24. FUNERAL DIRECTOR: Peter Whaley — ADDRESS: Selbyville, Del.

25a. RECD BY REGISTRAR DATE: APR 14 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64